VIRGINIA ADAP APPLICATION

If you need assistance completing this application, please contact the Virginia Department of Health at 1-855-362-0658. The application may be mailed to Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street, Richmond, VA 23219 or faxed to 804-864-8050.

Did you:

1. Yes ☐ No☐ Answer all of the questions on the application?
2. Yes ☐ No☐ Include proof of Virginia residency if your current address is not in Virginia?
3. Yes ☐ No☐ Include proof of current income?
4. Yes ☐ I have health insurance ☐ Include a front & back copy of your health insurance card (if applicable)? ☐ No, I don't have health insurance.
5. Yes ☐ No ☐ Sign and date application?
6. Yes ☐ No☐ Is the Medical Certification Form completed with HIV Diagnosis?

- ❖ If you checked "yes" to all questions above, your application will be processed within 72 hours.
- ❖ If you checked "I don't have health insurance" to question 4 above but checked "yes" to all other questions, your application will be processed within 72 hrs.
- ❖ If you answered "No" to any questions above, not including question 4, your application cannot be processed. Please send only completed application.

Please use the checklist above to confirm that the application is complete. Who is submitting this application (Client, Case Manager, Other)?:
Name: Contact Phone Number:
Relationship to Client:
Signature: Date:

APPLICANT AND CONTACT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Social Security No.		Date of Birth	
Language Preference			
Primary Phone	Secondary Phone		
May VDH leave a detailed voice mail on your (Check all that apply)?	☐ Primary Phone	☐ Secondary Phone	
☐ I don't have a phone, the best way to reach me is:			
May Virginia ADAP share your information with an alternate contact that you provide?	YES ☐	NO ☐	
If YES, name of alternate contact		Relationship of contact	
Phone number of contact			

DEMOGRAPHICS						
Current Gender	☐ Male	☐ Female	☐ Transgender (Male to Female)	☐ Transgender (Female to Male)	☐ Unknown	
Sex at Birth	☐ Male	☐ Female				
Race and Ethnicity (Please answer for RACE and ETHNICITY, as well as IF questions if applicable)						
Race (Check all that apply)	☐ White	☐ Black or African American	☐ Asian (Please answer follow-up)	☐ Native Hawaiian/Pacific Islander (Please answer follow-up)	☐ American Indian or Alaska Native	
IF Asian (Check all that apply)	☐ Asian-Indian	☐ Chinese	☐ Filipino	☐ Japanese	☐ Korean	☐ Vietnamese ☐ Other Asian Origin: _____
IF Native Hawaiian, Pacific Islander (Check all that apply)	☐Native Hawaiian	☐ Guamanian or Chamorro	☐ Samoan	☐Other Pacific Islander:_____		
Ethnicity (Check one)	☐ Non-Hispanic	☐Hispanic/ Latino(a) (Please answer follow-up)	**IF Hispanic/Latino(a) (Check all that apply)** ☐ Mexican, Mexican-American, Chicano	☐ Puerto Rican	☐ Cuban	☐ Other Hispanic Origin: _____

HEALTH DEPARTMENT
Please list the Local Health Department or Site you will/would use for medicine pick up:

INCOME						
Current Family Income: $_____	☐ Annual	☐ Monthly	☐Other, specify_____			
Number of persons in your family unit (include yourself):_____	**Are you currently employed?**	☐ Yes	☐ No			
Please check any other types of income you currently receive	☐ Alimony	☐ Child Support	☐Unemployment	☐Retirement/ Pension	☐ Social Security Income/Social Security Disability Income	☐ Other, specify _____

MEDICAL PROVIDER INFORMATION		
Name of prescribing physician:		
Name of physician's medical practice:		
Physician Street Address		
Physician City	Physician State	Physician ZIP
Physician Phone	Physician Fax	

INSURANCE INFORMATION				
Do you currently have any type of insurance?	☐Yes	☐No	☐ Don't Know	
If Yes, check all types that you currently have:	☐ Private Insurance, Employer	☐ Private Insurance, Individual	☐ Medicare A/B	☐Medicare D
	☐ Indian Health Services (IHS)	☐ Medicaid/CHIP/Other Public Plan		
		☐ VA/TRICARE /Other Military Plan	☐ Other, specify_____	
If you have insurance, does it provide prescription drug coverage?	☐ Yes	☐No	☐ Don't Know	
Are you applying or have you applied for Medicaid?	☐ Yes	☐ No	☐ Don't Know	
Are you applying or have you applied for Medicare?	☐ Yes	☐ No	☐ Don't Know	
If Yes, Have you applied for Medicare Part D (medication coverage)?	☐ Yes	☐No	☐ Don't Know	
If Yes to Medicare Part D, have you applied for the Low Income Subsidy (LIS)?	☐ Yes	☐No	☐ Don't Know	
Are you applying or have you applied for Social Security Income (SSI) or Social Social Security Disability Income (SSDI)?	☐ Yes, for SSI	☐Yes, for SSDI	☐ No	☐ Don't Know

CONSENT AND SIGNATURE

I understand it is my responsibility to provide medical status and proof of income every six months. I further understand it is my responsibility to notify VDH of any changes in my contact information, income or insurance status (if applicable). Failure to provide the necessary documentation could jeopardize my approved assistance through the Virginia Department of Health.

I understand my information is being entered into a database by the Virginia Department of Health. I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and/or other health care benefits. I request a third party payer to pay any authorized benefits to VDH on my behalf. I hereby give my consent to VDH to obtain, verify, and/or release my demographic, medical, prescription, and/or insurance coverage information, with other entities as necessary to effectively manage my medication access. Information may be shared with but is not limited to the following: physician, health department personnel, other Division of Disease Prevention programs (including Surveillance, Care and Prevention), treatment center personnel, pharmacy services provider, referral source, clinic, insurance broker and/or insurance carrier. VDH agrees to treat any and all such information as confidential.

I understand that this consent will remain in effect as long as my dependent or I remain on ADAP or until I withdraw it.

I have read, understand and agree to the above Client Responsibilities and Release of Consent. I verify that the information provided in this application is complete and accurate to the best of my knowledge.

_____ _____

Signature of Client, Parent/Legal Guardian or Person acting in Loco Parentis Date Signed

_____

Relationship (If signature is not of Client)

_____ _____

Signature of Person Obtaining Consent Date Signed

In order to process your application in a timely manner it is important that the application is complete. If your application is not complete, we will not be able to process your application and there may be a delay in obtaining your medication.

MEDICAL CERTIFICATION FORM

Please complete and return to: Virginia Dept. of Health, Attn: Eligibility, 1st floor, P.O Box 2448, Room 326 Richmond, VA 23218 or fax to 804-864-8050. Call 855-362-0658 with any questions.

MEDICAL PROVIDER CONTACT INFORMATION		
Date Form Completed:		
Client First Name:	Client Last Name:	Client Date of Birth:
Person Completing Form		
Phone Number for Person Completing Form		
Medical Provider Name		
Medical Practice Name		
Provider Phone Number	Provider Fax Number	

CLIENT MEDICAL INFORMATION			
Current Disease Status	☐ HIV Positive, not AIDS	☐ HIV Positive, AIDS status unknown	☐ CDC-defined AIDS
Current CD4 Count	_____	Date of Current CD4 Count	____/____/_____
Current Viral Load	_____	Date of Current Viral Load	____/____/_____
Date of Last HIV Medical Care Visit	___/____/_____		

List Medications Prescribed for this Client (or attach a medication list)

MEDICATION NAME	DOSAGE

I certify that I am treating the above named client for HIV and that all information provided in this form is accurate and complete to the best of my knowledge.

_____ _____

Signature of Physician Date Signed

HEALTH COVERAGE INFORMATION (OPTIONAL)		
Have you used tobacco products in any form within the last 12 months?	☐ Yes	☐ No
If, Yes please provide the type, amount of tobacco used and frequency?		